STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00095975. Complaint IN00095975 - Substantiated. Federal/state deficiency related to the allegation is cited at F323. Survey dates: September 1 and 2, 2011 Facility number: 000192 Provider number: 155295 AIM number: 100291120 Survey team: Donna M. Smith, RN Census bed type: SNF/NF: 66 Total: 66 Census payor type: Medicare: 14 Medicaid: 43 Other: 9 Total: 66 Sample: 4 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review 9/08/11 by Suzanne	F0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* We respectfully request a desk review of the plan of correction for alleged deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=E	Williams, RN The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, record review, and interviews, the facility failed to ensure a timely assessment and evaluation of residents known to remove their alarms and to ensure personal body alarms being utilized were functional and/or clipped to the resident to maintain the safety of the resident in the prevention of falls and injuries, for 4 of 4 residents reviewed for falls in a sample of 4. (Resident #'s B, C, D, and E) Findings include: 1. On 9/01/11 from 2:10 p.m. to 2:55 p.m. during the initial tour with LPN #1, Resident #B was observed in her wheelchair in her room with her personal body alarm (PBA) clipped to the wheelchair and not to her. At this same time during an interview, LPN #1 indicated the PBA should be clipped to the resident as she attached it to the resident's top. At this same time, LPN #1 asked the resident if she had unclipped the PBA with the resident shaking her head in a negative manner. The resident did indicate the clip bothered her when it was clipped along the back of the wheelchair	F0323	We respectfully request a desk review of the plan of correction for alleged deficiencies. **F 323** **483.25 (h) Freee of accidents/hazards/supervisio n/devices.** The facility must ensure that the residents envioronment remains free of accident hazards as is possible: and each resident recieves adequate supervision and assistance devices to prevent accidents, I. Due to the nature of the survey, we are unable to identify the residents potentially affected by the alleged deficient practice. In house residents have been assessed to assure appropriate interventions are in	09/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	where she leaned back. On 9/01/11 at 5:20 p.m., Resident #B was observed in her wheelchair in the hallway. Her PBA was observed unclipped as she propelled herself down the hallway. At this same time during an interview, the Housekeeping Supervisor indicated her PBA alarm was not clipped to the resident and proceeded to clip the PBA to the resident's top and informed an unidentified nursing staff she had reclipped the PBA to the resident's top. On 9/02/11 at 9:45 a.m. during an interview, the DON indicated the resident was changed to a pressure alarm last night due to the resident would remove her clip alarm. Resident #B's record was reviewed on 9/01/11 at 3:10 p.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, and peripheral neuropathy. The quarterly minimum data set assessment, dated 8/17/11, indicated the resident had difficulty with decision making requiring supervision. The resident required extensive assistance of 1 person with transfers and activities of daily living. The "FALL RISK ASSESSMENT," dated 8/05/11, indicated a score of 16 with a		place to attempt to decrease the risk for falls for residents identified high risk for falls. II. "Check Alarm for placement and function" has been added to the Vocollect documentation system to prompt nursing staff to verify and check placement. III. "Check Alarm for placement and function every shift" has been added to the MAR/TAR for residents who utilize alarms, to be signed off by liscenced nursing staff every shift. IV. Nursing staff has been re-educated on alarm placement, fall program and prevention. V. DON or designee will audit safety alarms on random shifts 3x's a week for 4 weeks, then weekly x's 2 months, then monthly x's 3 months. Staff non-compliance will be addressed with 1:1 education and progressive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	total score above 10 representing high risk for falls. The "FALL RISK CARE PLAN," originally dated 2/14/11 and re-evaluated on 8/17/11, indicated the problem at risk for falls due to incontinence, unsteady gait, cognitive impairment, dementia, poor safety awareness, non-compliance, weakness and history of falls. The interventions included, but were not limited to, pressure sensor pad in bed and the wheelchair. The "CHANGE OF CONDITION REPORT - SUSTAINED OR SUSPECTED FALL," dated 7/07/11, indicated the resident had fallen forward from the sitting position on her bed at 6:30 a.m. She was attempting to reach for an object. The resident denied hitting her head. The "Additional Circumstances R/T (related/to) this Fall" was the alarm failure or device was removed. The "POST - FALL DOCUMENTATION FLOW SHEET" indicated on 7/07/11 at 6:30 a.m. the resident was heard calling for help from her room. The resident was sitting on the floor next to her bed leaning on her right arm. She indicated she was reaching for a bobby pin on the floor. The bed alarm was found unplugged. The resident indicated she did not use the bed		disciplinary actions. Results will be reviewed monthly in QA meeting x 6 months and then quarterly with subsequent plan development and implemented as appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	alarm. No apparent injury was noted from the fall. The resident was educated to ask for help, and the alarm was plugged in. On 7/08/11 at 2:00 a.m., a 1 1/2 centimeter in diameter bruise was noted on the resident's chin and was tender to touch. 2. On 9/01/11 from 2:10 p.m. to 2:55 p.m. during the initial tour with LPN #1, Resident #D was observed lying in his bed in his room. When LPN #1 checked the bed alarm, it was not functioning. LPN #1 then removed it as a new bed alarm was obtained. At this same time during an interview, LPN #1 indicated the alarms should be checked every shift. On 9/02/11 at 9:50 a.m., information was requested concerning the resident's past falls from August 2010 to the present time. On 9/02/11 at 10:35 a.m. during an interview, the DON indicated she had not found any fall information for Resident #D and was still checking. Resident #D's record was reviewed on 9/01/11 at 3:45 p.m. The resident's diagnoses included, but were not limited to, dementia with intermittent disturbance of behavior, orthostatic hypotension, depression, and behavior disturbance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The quarterly minimum data set assessment, dated 8/10/11, indicated the resident had difficulty with decision making requiring supervision. The resident required extensive assistance of 1 person for transfers and activities of daily living. The physician order, dated 8/24/10, indicated pressure sensitive alarm on bed and check placement and function every shift. The "FALL RISK ASSESSMENT," dated 8/05/11, indicated a score of 14 with a total score above 10 represented high risk for falls. The "FALL RISK CARE PLAN,"originally dated 2/09/11 and re-evaluated on 8/09/11, indicated the problem was at risk for falls and injuries related to antidepressant use, incontinence, unsteady gait, cognitive impairment, dementia, poor safety awareness, non-compliance, weakness and history of falls. The interventions included, but were not limited to, pressure sensor pad in the bed and wheelchair. 3. On 9/02/11 at 9:30 a.m., Resident #E was observed in her wheelchair in the dining room with her personal body alarm (PBA) not functional as the timely			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	blinking light was not visible. At this same time during an interview, CNA #2 indicated the resident's PBA was turned off and was then presently turned on and functional. CNA #2 also indicated she would check the alarms often and then, asked the resident if she had turned her PBA off, which she denied. On 9/02/11 at 10:05 a.m. during an interview, LPN #5 indicated she checked PBA's frequently. She also indicated some residents, for example, Resident #E were known to turn their PBA's off at times. At this same time, she indicated when a resident fell, one should assess the resident, notify the physician and family and report. After the resident was safe, the fall packet would be initiated. Resident #E's record was reviewed on 9/02/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, dementia. The quarterly minimum data set assessment, dated 6/17/11, indicated the resident rarely made decisions. The resident required extensive assistance of 1 person for transfers and activities of daily living. The "FALL RISK ASSESSMENT," dated 6/11/11, indicated a score of 7 with a total score above 10 represented high risk for falls.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The "INTERDISCIPLINARY PROGRESS NOTES/CARE CONFERENCE NOTES," dated 8/09/11, indicated the resident utilized a chair alarm requiring assistance with transfers.

The "*Narrative Nurses Notes/Additional Skilled Observations & Assessment," dated 1/14/11 at 9:00 a.m. indicated the resident was seen pushing her w/c (wheelchair) down the hall. A staff member indicated she had seen the resident turn off her alarm and put the pad and alarm into her purse. She was then redirected and returned to her wheelchair with the alarms in place and functioning.

The "NURSE'S NOTES" indicated on 7/10/11 at 2:00 p.m. the resident was up in her wheelchair as usual propelling herself around. She had attempted to transfer herself 2 times to the toilet this day with frequent reminders given to ask for assistance without success.

4. Resident #C's record was reviewed on 9/01/11 at 4:10 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, coronary artery disease, and anxiety. The quarterly minimum data set assessment, dated 8/19/11, indicated the resident made his own decisions. The resident required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	extensive assistance of 1 person for transfers and activities of daily living. The "FALL RISK ASSESSMENT," dated 8/09/11, indicated a score of 12 with a total score above 10 represented high risk for falls. The "FALL RISK CARE PLAN,"originally dated (unclear)/14/11 and reevaluated on 8/12/11, indicated the problem was at risk for falls and injuries related to medications (antidepressant and diuretic), Parkinson's, unsteady gait, and history of falls. The interventions included, but were not limited to, pressure sensor pad in the bed and wheelchair and dicem in recliner. The "IDT (Interdisciplinary Team) POST-OCCURRENCE REVIEW," dated 11/17/10, indicated the resident had fallen on 11/16/10. The resident had tried to self transfer and ambulate to the bathroom when he lost his balance and fell. The safety devices were pressure alarm, chair alarm, and bed alarm. The "CHANGE OF CONDITION REPORT - SUSTAINED OR SUSPECTED FALL" records indicated the following: On 4/11/11 at 7:15 p.m., the CNA was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ambulating the resident from his bed to the commode and had turned to free the oxygen tubing when the resident lost his balance and fell. The resident had a skin tear on his right arm. On 7/15/11 at 9:45 p.m., the CNA was assisting the resident to the bathroom when the resident lost his balance and was lowered to the floor. The resident had a skin tear on his left arm. On 8/26/11 at 5:15 p.m., the resident was anxious to show his wife he could walk independently with a walker. As he was ambulating with the walker with his wife present, he lost his balance and fell down in the hallway on his right side. The resident and his wife indicated the resident did not hit his head. The resident received skin tears to his right arm and hand. The "NURSE'S NOTES" indicated the following: On 8/16/11 during the 10 p.m. to 6 a.m. period, the resident was up in the hallway walking without assistance. The CNA on duty directed and assisted the resident back to his room. At this same time the bed alarm was not found to be in place with a new alarm obtained and placed on the bed. The resident was also reeducated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to use the call light for assistance. On 8/26/11 at 5:15 p.m., assistance was summoned at the end of the hallway due to the resident had fallen while ambulating with his walker with his wife with him. His wife reported the resident had wanted to go on a walk with his walker to show her he was able to walk. The resident had skin tears to his right elbow, right ring finger, and an unspecified area on the right lower back. On 8/26/11 at 7:08 p.m., the resident had requested a pain medication. After assisting a resident with a complaint of a low blood pressure, the nurse returned to the resident's room. The resident was found lying on his left side on the floor. His face was described as being a "very dark purple." The resident had vomited a moderate amount of food with a moderate amount of mucous from his nose. His head was laying in a small amount pool of blood. The resident had been sitting in his recliner with no indication if the alarm was sounding. All vital signs were absent. There was no information to indicate if the resident had fallen first or had passed away prior to the fall. On 9/02/11 at 9:20 a.m. during an interview, Physical Therapist (PT) Assistant #3, who had worked with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #C, indicated he had difficulty with his balance. He also indicated although the resident had a medium level of balance and would require the assistance of one, Resident #C had recently been discharged from therapy due to the resident had reached his level of balance. On 9/02/11 at 9:25 a.m. during an interview, LPN #4 indicated she took care of the resident and he did utilize both chair and bed alarms. She indicated he was unsteady on his feet and always had to have assist to go to the bathroom, for example. She also indicated she would check alarms frequently on fall risk residents. On 9/02/11 at 9:45 a.m. during an interview, the Director of Nursing (DON) indicated she did not think Resident #C had alarms due to Physical Therapy had discontinued them. She also indicated she checked with the nurse on duty on 8/26/11, and she had indicated the resident did not have any alarms on. She then indicated 2 reasons the alarms could had been off/discontinued were due to the resident kept taking the alarm off and/or the wife would shut the alarm off. On 9/02/11 at 9:55 a.m. during an interview, Physical Therapist (PT) #4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident #C had alarms as he was not safe without them. She indicated the resident had an unsteady gait. On 9/02/11 at 10:35 a.m. during an interview, the DON indicated Resident #C did utilize alarms as indicated on the dated 7/15/11 "CHANGE OF CONDITION REPORT - SUSTAINED OR SUSPECTED FALL" record. 5. On 9/02/11 at 8:40 a.m. during an interview, the Director of Nursing (DON) indicated the information concerning a resident's alarms had been left off of the physician's rewrite last month and was to be placed back on the rewrites. On 9/02/11 at 10:35 a.m. during an interview, the DON indicated she was not going to use the clip alarms and were changing to only pressure alarms. On 9/02/11 at 12:05 p.m. during the exit conference with the DON, ADON (Assistant Director of Nursing), and Administrator, no further information was provided concerning falls. 6. The "Falls Management" policy was provided by the Administrator on 9/02/11 at 8:35 a.m. This current policy indicated the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...PURPOSE * To evaluate risk factors and provide interventions to minimize risk, injury, and occurrences. ...ASSESSMENT GUIDELINES May include, but are not limited to: * Fall Risk Factors / Fall History * MDS (Minimum Data Set) / Falls Care Area Assessment * Post-fall Evaluation and Observation ...FALL PREVENTION PROCEDURE 1. Evaluate risk factors for sustaining falls upon admission, with comprehensive assessments, and while conducting interdisciplinary care plan reviews. ...3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries. PROCEDURE FOR RESPONDING TO A FALL ...3. Address any emergent conditions or first-aide needs. Initiate neurological checks for any unwitnessed falls and falls with actual or suspected head injury or trauma....." The fall packet information was provided by LPN #1 on 9/02/11 at 10:20 a.m. This current packet included the forms as follows: "Charge Nurse Reminder List,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	INTERVIEW/INVESTIGATIVE RECORD, CHANGE OF CONDITION REPORT - SUSTAINED OR SUSPECTED FALL, POST - FALL DOCUMENTATION FLOW SHEET, EPISODIC CARE PLAN: POST-FALL, NEUROLOGICAL ASSESSMENT FLOW SHEET, RESIDENT / VISITOR INCIDENT REPORT," and how "TO SET UP PACKETS FOR USE." This federal tag relates to complaint IN00095975. 3.1-45(a)(2)			